Care Coordination Team or CCT

Who are we?

Multidisciplinary team based in ED consisting of:
Occupational Therapists (OT) and Physiotherapists (PT)

Service Operations:

Joint OT and PT team – generic role.
Upskilling of both professions to allow therapist to effectively manage most patients (pt) wholly.
7am -9pm Monday to Sunday
Main contact number is **X 76729, X 76926, X 76927**
Identified in ED by bright blue scrubs
Accept direct referrals but also screen for patients on EDIS who are likely to need our input
See pts' in all areas of ED

We aim to achieve:

1. Safe and effective discharge of patients from ED into the community. Patients are comprehensively assessed to determine their suitability for discharge and interventions are provided to assist the discharge. (for example RITH, Silver Chain HDS etc). Prevent hospital admissions where possible.
2. Initiation of referrals to hospital and community services
3. Early intervention to those pt's requiring admission
4. Work closely with the GAT team to provide comprehensive geriatric care in ED

Target Groups:

Core business groups include:
Falls: Pt's presenting with fall who are likely for discharge
Fractures: Fractured wrist/humerus/ankle etc.
Back pain: Pt's who have mobility or functional problems
Chest: Ex ICU patients post extubation who are requiring chest maintenance or Acute Respiratory Complaints
Musculoskeletal: Sporting injuries e.g ankle sprains, knee sprains
Frail elderly/Acopia: Work closely with GAT team for comprehensive assessment
Any conditions: any other condition where there is concern re: ability to manage at home

Profession Specific

Physiotherapy: Vestibular Ax/Rx, respiratory Ax/Rx for patients at risk of clinical deterioration, mobility review post ICU toxicology patients, spinal bracing (Short and Long Miami J and Jewett via orthotist)
Occupational Therapy: hand injuries including splinting, complex discharge planning including equipment and cognitive assessments including head injury and concussion screening

Fast track: See patients who have fractured or sprain/strain but are more complex and need further allied health intervention. I.e. elderly, non-weight bearing, not managing with axillary crutches etc.
Young, fit patients who have sprained or fractured do not need referring to us.

MAU patients: Patients who would benefit from early allied health assessment, falls risk management and functional mobility reviews in ED

Assessment

Our assessments is aimed at complimenting the medical assessment

Assessment includes:
- Functional Assessment
- Mobility Assessment
- Cognitive assessment
- Falls Risk Assessment

Interventions:

Education/advice re: injury management, falls prevention, back care.
Home environment assessment and equipment provision
Splints/slings
Mobilisation
Settling Service
CCT2 home service
Refer on to outpatient/community services (see below)

Onwards referrals:

Referral to other members of our Social Work for further Assessment
Referral to Outpatient and Community teams such as:

- FRAC
- Falls Clinic and Falls Specialist
- CCT2home
- RITH OT/PT – rehab within the home
- RAILS
- Home care services (SW)
- Outpatient or community Physio
- Continence Clinic
- Parkinsons Clinic
- Memory Clinic
- CoNeCT services